Preferred Pediatrics

I hereby grant permission for the physician and/or staff of Preferred Pediatrics to release medical information to:

Parent: □ YES □NO

To release medical information to the parent (if child is a minor)/self (if patient is 18 or older), Preferred Pediatrics may:

a. Call my place of employment. (Results will not be left by message)
□ YES □NO

b. Leave medical information on my identifiable voicemail?
□ YES □NO

c. Only call me directly by phone at my residence. I understand if I am unable to receive my call that a message will be left requesting that I call the office to receive the information.
□ YES □NO

Other family members: □YES □NO (If yes, please specify)

1. Name _____
   Relationship _____
   Phone Number _____
2. Name _____
   Relationship _____
   Phone Number _____

The following individuals have my permission to bring my child to his/her appointments in my absence:

3. Name _____
   Relationship _____
   Phone Number _____
4. Name _____
   Relationship _____
   Phone Number _____

Name of Patient (print): _____

Name of Parent (print): _____

Signature of Parent: _____ Date: _____